FETAL INFANT MORTALITY REVIEW (FIMR) PROGRAM

Background

The California Fetal Infant Mortality Review (FIMR) Program is modeled after the National FIMR Program of the American College of Obstetricians and Gynecologists (ACOG). In 1991, California was the first state to establish a state-directed FIMR Program. The Maternal and Child Health (MCH) Branch funded 12 projects, two of which were also demonstration sites of the National FIMR Program. California has since expanded the FIMR Program to its current level of 17 local projects.

The FIMR Program is a method of understanding health care systems and social problems that contribute to preventable fetal and infant deaths and for identifying and implementing local interventions to rectify the identified problems. The FIMR Program empowers local community members to take the necessary steps to improve fetal and infant mortality within their own communities. It is a community-based, action-oriented process that leads to improvement in health and social services for families. Through FIMR, the community becomes the expert and gains knowledge of the entire local service delivery system and community resources for women, infants, and their families. FIMR is designed to:

- Examine and identify factors that contribute to fetal, neonatal, and post-neonatal deaths by establishing ongoing case review and community action teams.

- Make recommendations that address the contributing factors.

- Mobilize the community to implement interventions that lead to system and community changes, which lead to the reduction of fetal/infant deaths.

FIMR includes the following four components of a strong public health program:

- Assessment of fetal/infant deaths in local communities via data collection and analysis of case reviews which is done by review of vital statistics, abstraction of medical/psychosocial records, family interviews, surveys of local community resources, and focus groups with community members to determine perceptions of the problem.

- Program planning by organizing community members to develop recommendations and a plan of action based on the results of the assessment to address the medical, social, environmental and other factors which lead to fetal and infant deaths.

- Implementation of primary, secondary and tertiary prevention interventions. These interventions do not concentrate on individual behavior change alone, but mobilize community members to look at system changes and institutionalization of long-term policies.

- Evaluation and monitoring program outcomes such as the implementation and maintenance of local policies to increase access to health care.

Each FIMR Program has a Case Review Team (CRT) and a Community Action Team (CAT). The FIMR Coordinator selects infant and fetal death cases for review. The CRT conducts the review of the selected cases, performs family interviews, and makes recommendations to avoid similar future deaths. The Community Action Team takes the recommendations and develops interventions to be implemented into the local health system and community.

1.0 LOCAL ACTIVITIES

1.1 Policy: The State MCH Branch funds local health jurisdictions to conduct a FIMR Program to identify local system and community problems that contribute to fetal and infant deaths and implement solutions to prevent future deaths.

1.2 Requirements:

1.2.1 Each agency receiving FIMR funds is required to perform the following functions:

- Examine and identify factors that contribute to fetal, neonatal, and post-neonatal deaths by establishing ongoing case review and community action teams.

- Make recommendations that address the contributing factors.

- Mobilize the community to implement interventions that lead to system and community changes, which lead to the reduction of fetal/infant mortality.

1.2.2 Each agency must have a CRT that consists of culturally competent medical and non-medical representatives. Members of the CRT should represent a broad range of professional public and private agencies. Agencies and organizations may include health, welfare, education, advocacy groups, and organizations that provide services and resources for women, infants, and families. Membership is modified as priorities and at-risk populations change.

1.2.3 Each agency must have a CAT that reflects the needs and diversity of the community and includes membership that can define and organize community-based system changes that arise from case reviews. Crossover representation between CRT and CAT members facilitate the identification, development, and implementation of interventions.

1.2.4 The CAT shall have coordination and/or representation from related state and local programs serving women and children, such as Sudden Infant Death Syndrome (SIDS); Women, Infants, and Children (WIC); and Black Infant Health (BIH).

1.2.5 Membership of the CAT is to be modified appropriately as the priorities and at-risk populations for review change. The team may include, but not be limited to representatives from:

- Health professionals
- Social services agencies
- Child health organizations
- Community-based organizations
- Political leadership groups
- Faith community groups
- Neighborhood organizations
- Educational organizations
- Housing and tenants' rights organizations
- Local businesses
- Parents who have lost an infant

1.2.6 The local FIMR Program must document community involvement by keeping on file meeting sign-in sheets and minutes.

1.2.7 The case-based recommendations and interventions should center on local factors or address broad questions of system performance and public policy. Interventions should include, but not be limited to changes in:

- Public health and social policies.
- Health service delivery systems, networks, and practices.
- Professional training and education, community-based education.
- Patterns of community knowledge, skills, lifestyles, and norms.

1.2.8 Each agency must have standardized data collection and reporting.

1.2.9 Each agency must comply with the Scope of Work (SOW) as negotiated with the MCH Branch.

1.3 Procedures

1.3.1 Submit an Annual Progress Report according to the MCH Programs Reports Section 1.3. Include in the report:

- A copy of the current letter from the local health officer granting approval to conduct the FIMR program.

- For each case reviewed:
  - Case Review Summary Form for each
  - Fetal Infant Mortality Issues Checklist
  - Case Vignette, hard copy and diskette
  - FIMR Case Tracking Log

2.0 PERSONNEL

2.1 Policy: Each FIMR Program must have appropriately trained staff to perform functions, such as FIMR Coordinators, Records Abstractors, Parental Interviewers, and Data Managers. These roles may be combined or shared as staffing availability permits. The MCH Branch must approve the FIMR Coordinator and any/all changes to the Coordinator position, including allotted time, duties, job specifications, and organizational charts.

2.2 Requirements of FIMR Coordinator:

2.2.1 Obtain local case review authority from the health officer or a local Committee for the Protection of Human Subjects to conduct ongoing FIMR reviews. If unable to obtain authority for records review locally, must obtain authorization from parents or legal guardians of the deceased.

2.2.2 Develop and maintain protocols and procedures for the review of cases according to state and national FIMR guidelines.

2.2.3 Provide leadership and direction to CRTs and CATs.

2.2.4 Collect and analyze local data pursuant to MCH guidelines.

2.2.5 Abstract information from various data sources and summarize the information for CRTs that maintain client confidentiality.

2.2.6 Conduct parental interviews and summarize the information for CRTs.

2.2.7 Distribute findings of the case reviews to the CAT with recommendations for action.

2.2.8 Attend and participate in statewide or regional meetings and trainings as scheduled and coordinated by the MCH Branch.

2.2.9 Submit to CRT and CAT summarized information from the parental interviews and other data sources.

2.3 Requirements of CAT:

2.3.1 The CAT will review the findings of the CRT and recommend and implement community and system changes that will assist in preventing future fetal/infant deaths.

2.3.2 Communities with already established community coalitions/groups for which fetal/infant mortality issues are a priority may have those coalitions assume the role of the CAT, when appropriate. The community coalitions must collaborate closely with CRT.

2.4 Procedures:

2.4.1 Submit annually to the MCH Branch a written copy of the local authority to conduct ongoing FIMR case reviews.

2.4.2 Submit procedures, protocols, data collection forms, which include the "Issues Associated with Fetal-Infant Mortality", Case Summary, and FIMR tracking log along with the annual progress report to the MCH Branch.

2.4.3 Submit to MCH local data and progress report information, pursuant to the MCH Program Report Section 1.3.

3.0 PATIENT/CLIENT EDUCATION AND COMMUNITY AWARENESS

3.1 Policy: The local FIMR Program is to involve community members in all aspects of the program, including review of fetal/infant death cases, planning and implementation of interventions, and evaluations.

3.2 Requirements:

3.2.1 Diversity among members of the CRTs and CATs must reflect the community served. A diverse membership of the teams is essential to the success of the FIMR program.

3.2.2 The CRTs and CATs must involve local community members in order to:

- Gather insight into the local determinants.
- Elicit community concerns and desires.
- Assure that the local community will be vested in the process.

3.3 Procedures:

3.3.1 Document meeting sign-in sheets and maintain meeting minutes.

3.3.2 Describe community involvement in the progress reports.